

Online Renewal Is Available

At

www.tennessee.gov/health

INSTRUCTIONS FOR RENEWAL APPLICATION

1. Please fill in all requested information. Make sure to mark the box beside the profession for which you wish licensure renewal.
2. Carefully read all questions on this application form. Circle "Yes" only if the statement(s) applies to you. Do not write "NO" beside the statement if it does not apply to you.
3. Sign, date the application, and return it.

If you do not sign and date the application, it WILL be returned to you. Failure to sign and date this application will cause a delay in issuing your renewal certificate and may cause you to incur further cost.

4. The renewal fee for your profession is listed below. Please make your check or money order payable to the Department of Health. DO NOT SEND CASH.
5. Pursuant to T.C.A. §63-1-108, it is the licensee's responsibility to keep the Board apprised of any change of address within thirty (30) days of the change. For the purpose of the Board proving it has sent you your renewal application or license, it is sufficient to send said documentation to the address found in your licensure file.

Medical Doctor (1606)	\$ 235	Orthopedic Physician Assistant (3629)	\$ 260
Osteopathic Physician (1907)	\$ 385	Medical Office X-Ray Operator (1637) Limited	\$ 60
Athletic Trainer (3527)	\$ 130	Medical Office X-Ray Operator (1637) Full	\$ 60
Physician Assistant (3628)	\$ 260	Osteopathic Medical Office X-Ray Operator (1944) Limited	\$ 60
Acupuncture (2483)	\$ 510	Osteopathic Medical Office X-Ray Operator (1944) Full	\$ 60
ADS (2483)	\$ 60	Midwifery (3045)	\$ 510
Perfusionist (2984)	\$ 360		

_____ -002 \$ _____

_____ -006 \$ _____

**TENNESSEE DEPARTMENT OF HEALTH
MEDICAL BOARD UNIT RENEWAL APPLICATION**

Online Renewal is now available at www.tennessee.gov/health

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON THIS FORM

You Must Check One:

- | | |
|---|---|
| <input type="checkbox"/> Medical Doctor (1606) | <input type="checkbox"/> Orthopedic Physician Assistant (3629) |
| <input type="checkbox"/> Osteopathic Physician (1907) | <input type="checkbox"/> Medical Office X-Ray Operator (1637) Limited |
| <input type="checkbox"/> Athletic Trainer (3527) | <input type="checkbox"/> Medical Office X-Ray Operator (1637) Full |
| <input type="checkbox"/> Physician Assistant (3628) | <input type="checkbox"/> Osteopathic Medical Office X-Ray Operator (1944) Limited |
| <input type="checkbox"/> Acupuncture (2483) | <input type="checkbox"/> Osteopathic Medical Office X-Ray Operator (1944) Full |
| <input type="checkbox"/> Midwifery (3045) | <input type="checkbox"/> ADS (2483) |
| <input type="checkbox"/> Perfusionist (2984) | |

Lic./Cert. No. _____

Expiration Date: _____

Social Sec. No:

_____ - _____

Name and Mailing Address

Birth Date: Mo/Date/Yr

_____ / _____ / _____

Home Phone:

Work Phone:

Is this a change in your mailing address?

Yes ☐ No ☐

Work Address:

CAREFULLY READ ALL QUESTIONS

Circle YES if the following applies to you:

I have been convicted of a crime and I have not previously notified the Board in writing of that action **YES**

My license has been disciplined in another state and I have not previously notified the Board in writing of that action **YES**

I am currently in poor physical and/or mental health **YES**

My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry) **YES**

Have you ever been denied a license to practice your profession in another jurisdiction **YES**

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two (2) years, list those states. _____



MAIL TO:

**Medical Board Unit
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243**

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competency requirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotated and the Official Compilation Rules and Regulations of the State of Tennessee regarding the practice of my profession.

SIGNATURE

DATE

**MAKE CHECK OR MONEY ORDER PAYABLE TO THE DEPARTMENT OF HEALTH
DO NOT SEND CASH**

Total Paid: \$ _____

MA/G6019279/BME